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In the Supreme Court of the United States

OCTOBER TERM, 1985

CHARLES ATKINS, COMMISSIONER,
MASSACHUSETTS DEPARTMENT OF PUBLIC WELFARE,
PETITIONER

v.

SANTOS RIVERA, ET AL.

ON WRIT OF CERTIORARI TO THE SUPREME JUDICIAL COURT OF MASSACHUSETTS

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONER

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QUESTION PRESENTED

Whether a regulation of the Secretary of Health and Human Services that permits states participating in the Medicaid program to use up to a six-month period for computing the excess income an applicant must spend on medical care before qualifying for Medicaid is arbitrary, capricious or otherwise unlawful.

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INTEREST OF THE UNITED STATES

Medicaid is a joint federal-state program "providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." *Harris* v. *McRae*, 448 U.S. 297, 301 (1980). In developing plans for administering the Medicaid program, states are given discretion to determine who will receive Medicaid assistance as well as the kinds of assistance provided. State Medicaid plans, however, must comply with requirements imposed by the Act and by the Secretary of Health and Human Services. 42 U.S.C. 1396a.

The United States has a significant interest in the resolution of this case. The Supreme Judicial Court of Massachusetts held that the Commonwealth of Massachusetts violated the Medicaid Act by using a six-month period for determining the excess income that an applicant must spend on medical care before

qualifying for Medicaid. The court held that Massachusetts must use a one-month period. Massachusetts' choice of a six-month period, however, is specifically authorized by a regulation adopted by the Secretary at the inception of the Medicaid program. See 42 C.F.R. 435.831. Presently, some 29 states participating in the Medicaid program use other than a one-month period.

In the Secretary's judgment, the regulation authorizing states to select up to a six-month period furthers substantial policies that underlie the Medicaid program. It allows participating states the choice of targeting their limited financial resources at the most needy individuals and eases the administrative burdens placed on the states. The decision below, by invalidating the Secretary's longstanding regulation, substantially disrupts the operation of the Medicaid program. This result, if upheld by this Court, would increase the cost of participating in that aspect of the Medicaid program at issue in this case—a program that is wholly voluntary for the states—and would thereby raise the prospect that, rather than incur these added expenses, states will curtail the scope of covered services, restrict eligibility, or even withdraw from the program altogether.

STATEMENT

1. Congress established the Medicaid program in 1965 "for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." *Harris* v. *McRae*, 448 U.S. 297, 301 (1980); see *Schweiker* v. *Gray Panthers*, 453 U.S. 34, 36 (1981). As a cooperative federal-state program,[1] Medicaid

[1] Both federal and state funds are used to finance the program. See 42 U.S.C. 1396b.

leaves the decision whether to participate entirely to the discretion of each state. Once that initial decision has been made, states electing to participate must comply with requirements imposed by the Act and by the Secretary of Health and Human Services. See 42 U.S.C. 1396a; *Gray Panthers*, 453 U.S. at 37.

Individuals covered by certain cash assistance programs—Supplemental Security Income for the Aged, Blind, and Disabled (SSI) (42 U.S.C. 1381 *et seq.*) and Aid to Families with Dependent Children (AFDC) (42 U.S.C. 602 *et seq.*)—automatically qualify for Medicaid. Thus, states that choose to participate in the Medicaid program are required to provide Medicaid to these persons, termed the "categorically needy." See 42 U.S.C. 1396a(a)(10)(A)(i); 42 C.F.R. 435.4, 435.110(a), 435.120(a).[2] At its op-

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[2] When Medicaid was enacted in 1965 there was no SSI program. Rather, there were three separate state-administered programs for the aged, blind, and disabled. See 42 U.S.C. (1970 ed.) 301 *et seq.* (Old Age Assistance); 42 U.S.C. (1970 ed.) 1201 *et seq.* (Aid to the Blind); 42 U.S.C. (1970 ed.) 1351 *et seq.* (Aid to the Permanent and Totally Disabled). In 1972, Congress replaced these programs with SSI. Pub. L. No. 92-603, Tit. III, 86 Stat. 1465, codified at 42 U.S.C. 1381 *et seq.* See *Gray Panthers*, 453 U.S. at 38.

Under the SSI program the federal government sets the standard of need, which often is much higher than the state standards set under the former state-run programs. Thus, with the enactment of the SSI program, it was easier to qualify for SSI, and Medicaid, since these people were now considered categorically needy. See *Gray Panthers*, 453 U.S. at 38. Congress feared that in some states this would lead to a dramatic increase in the number of persons who automatically qualify for Medicaid and that, faced with this fiscal burden, some states would withdraw from the Medicaid program. To avoid this problem Congress "offered what has become known as the '§ 209(b) option.'" *Gray Panthers*, 453 U.S. at 38; see 42 U.S.C. 1396a(f). This gives states the choice of providing Medicaid only to those SSI recipients who would have been

tion, a participating state may also provide coverage to other "less needy" individuals. See H.R. Rep. 213, 89th Cong., 1st Sess. 66 (1965); 42 U.S.C. 1396a (a)(10)(C). In general, these are people who would otherwise qualify for SSI or AFDC except that their income exceeds the levels set for these categorical assistance programs. See *Schweiker* v. *Hogan*, 457 U.S. 569, 572-573 (1982). They are referred to as the "medically needy." See *ibid.*; 42 C.F.R. 435.4.[3] The medically needy may qualify for Medicaid only if they incur medical expenses that reduce their income to the Medicaid eligibility income standard. See 42 U.S.C. 1396a(a)(17); 42 C.F.R. 435.831(c).[4]

2. The same initial steps are used for determining the Medicaid eligibility of the medically needy as are used for determining eligibility for SSI and AFDC assistance. See *Hogan* v. *Heckler*, 769 F.2d 886, 888 (1st Cir. 1985). First, gross income is calculated.

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eligible for Medicaid under the state standards in existence on January 1, 1972—*i.e.*, prior to the enactment of the SSI program. Those who receive SSI but fail to meet the preexisting state standards may qualify for Medicaid by spending their excess income on medical care. See *Gray Panthers*, 457 U.S. at 39 n.5. Massachusetts has not elected to limit coverage under Section 209(b) (86 Stat. 1389).

[3] This group may be subdivided into the "AFDC-related medically needy" and the "SSI-related medically needy," depending on the type of assistance for which the recipient would qualify were it not for the excess income.

[4] The income eligibility standard for the medically needy may not exceed 133⅓% of the highest payment made by the state under the state's AFDC program. See 42 U.S.C. 1396b(f)(1)(B)(i); 42 C.F.R. 435.811(c); *Schweiker* v. *Hogan*, 457 U.S. at 576-580. Thus, a person whose income falls between the AFDC eligibility standard and the Medicaid standard would qualify for Medicaid without incurring any medical expenses. 42 C.F.R. 435.831(b). The present case does not involve persons in that situation.

This may include money earned by the applicant, as well as by a third party such as a spouse or a parent. See 42 C.F.R. 435.821-435.823. Next, various deductions are subtracted from the gross income to arrive at "countable income." See 42 C.F.R. 435.831(a); 106 C.M.R. 505.200, 506.100-506.200.[5]

Up to this point there is no difference between the computations for determining eligibility for SSI, AFDC and Medicaid. For example, the deductions from income for a medically needy applicant must be the same as those allowed to applicants for the corresponding cash program, SSI or AFDC. See 42 C.F.R. 435.831(a). However, because the medically needy possess income above the Medicaid eligibility standard, determination of their eligibility involves an extra step not applicable to SSI or AFDC.

As noted above, before medically needy applicants qualify for Medicaid they must incur medical expenses that reduce their income ("spend down") to the Medicaid eligibility standard. This "spend down concept was incorporated into the Medicaid Act at its origin." *Winter* v. *Miller*, 676 F.2d 276, 277 (7th Cir. 1982); see also 42 U.S.C. 1396a(a)(17); H.R. Rep. 213, *supra*, at 68; S. Rep. 404, 89th Cong., 1st Sess. 78-79 (1965). Since the first Medicaid regulations were adopted in 1969 (45 C.F.R. 248.21(a)(4) (1970) (now 42 C.F.R. 435.831)), the Secretary has permitted states to compute the excess income that must be spent on medical care over a period of time up to six months. This period is referred to as the "spend down period."

3. Massachusetts is one of 34 states (along with the District of Columbia, Puerto Rico, and the Virgin Islands) that have elected to participate in the Med-

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[5] "C.M.R." refers to the Code of Massachusetts Regulations (Mass. Admin. Code tit. 106 (1983)).

icaid program and to provide coverage for the medically needy. Mass. Ann. Laws ch. 118E, § 1 (Law. Co-op. 1975). Like 29 of those states and the District of Columbia, Massachusetts uses a spend down period that is longer than one month,[6] specifically, a six-month period for determining an applicant's excess income. See Mass. Ann. Laws ch. 118E, § 10 (Law. Co-op. 1975); see also 106 C.M.R. 506.510. When the applicant's medical expenses are greater than this six-month total of excess income, he or she qualifies for Medicaid for the remainder of the six-month period.[7]

To illustrate: if an applicant has a monthly income of $400 and the Medicaid eligibility standard is $300 per month, his income for the six-month spend down period would be $2,400 (6 x $400) and the Medicaid standard for the period would be $1,800

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[6] See S.J.C. App. 168 ("S.J.C. App." refers to the joint appendix filed in the Supreme Judicial Court). The Secretary has advised us of several changes that have occurred since the chart appearing at S.J.C. App. 168 was prepared. Thus, five states (Texas, South Carolina, Georgia, Iowa, and Oregon) now offer Medicaid to the medically needy and use a multi-month spend down period. In addition, the period is now one month in Illinois and as long as six months in Oklahoma.

[7] To qualify, an individual need not actually spend the money on medical expenses but must only "incur" them during the six-month period. See 42 U.S.C. 1396a(a)(17), 1396b(f)(2). However, the individual cannot anticipate future medical expenses he believes may be incurred during the six-month period. See *Hogan* v. *Heckler*, 769 F.2d at 897-898; *Williams* v. *St. Clair*, 610 F.2d 1244, 1248 (5th Cir. 1980). For individuals in long-term care facilities, the Secretary permits the anticipated costs of long-term care to be taken into account at the outset of the spend down period. See S.J.C. App. 6. This is because of the unique statutory and administrative requirements applicable to Medicaid recipients in long-term care facilities. See 42 U.S.C. 1396p(c)(2)(B)(i); 42 C.F.R. 435.725, 435.733, 435.832.

(6 x $300). Thus, the applicant would then have $600 ($2,400 minus $1,800) in excess income that must be "spent down" on medical care before he qualifies for Medicaid. Once the applicant incurs these expenses he is eligible for Medicaid for the remainder of the six-month period. At the end of the six-month period, the applicant must again meet the spend down limit before qualifying for Medicaid assistance in subsequent periods. The spend down therefore is roughly comparable, in an operational sense, to the deductible in an insurance policy: it is the amount the individual must spend before payments are provided for any covered services.

4. Respondent Rivera is the mother of two children. Because her income is too high she cannot qualify for AFDC and therefore is not automatically eligible for Medicaid as categorically needy. She also failed to qualify as a medically needy Medicaid recipient because she had not spent down her excess income on medical care. After benefits were denied and respondent had exhausted her administrative remedies, she brought this class action in Massachusetts Superior Court claiming, among other things, that she was illegally denied Medicaid benefits by the State. Specifically, respondent alleged that her monthly income exceeded the Medicaid eligibility standard by $100.30 and that under Massachusetts's six-month spend down she was required to spend $601.80 on medical care in order to qualify for Medicaid. J.A. 19. Respondent further alleged that she did not meet the six-month spend down amount, but that if the State were required to use a one-month spend down, she would have qualified for Medicaid as medically needy during the month of February 1983, when she incurred medical expenses of $314. *Ibid.* Respondent claimed that the State's six-month spend down violated 42 U.S.C. 1396a(a)(10)(C)(i)(III)

and 1396a(a)(17) because the "same methodology" was not used for computing the income of the medically and categorically needy. J.A. 21-22.[8]

On cross-motions for summary judgment, the superior court ruled for respondent. Pet. App. A28-A45. First, it held that class certification was appropriate. *Id.* at A34. Turning to the merits, the court held (*id.* at A40-A41) that the State's six-month spend down period violated the "same methodology" provision of 42 U.S.C. 1396a(a)(10)(C)(i)(III). The court noted that AFDC eligibility is statutorily required to be computed over a one-month period (42 U.S.C. 602(a)(13)) but that respondent Rivera and other AFDC-related medically needy applicants had their spend down amount for Medicaid eligibility computed over a six-month period. Pet. App. A41. To the court, this set up two different eligibility standards for the AFDC categorically needy and the AFDC-related medically needy, thereby conflicting with Section 1396a(a)(10)(C)(i)(III). Pet. App. A41-A42.

The superior court rejected (Pet. App. A43) the State's argument that its six-month spend down was authorized by the Secretary's regulation (42 C.F.R. 435.831). The court found that the regulation had been supplanted by federal legislation in 1981 that mandated for the first time a one-month budget period for AFDC. Thus, the court concluded that the Secretary's regulation "would not control." Pet. App. A43.

5. The Supreme Judicial Court of Massachusetts affirmed. Pet. App. A1-A26. The court rejected the

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[8] Respondent also claimed (J.A. 20) that the State's method of computing gross income violated state law. The state superior court agreed with respondent (Pet. App. A38) but the Supreme Judicial Court reversed. *Id.* at A10-A22. That issue is not raised in this Court.

State's claim that because there is no spend down computation for determining AFDC eligibility, computing the spend down amount for the medically needy could not be governed by the "same [AFDC] methodology." *Id.* at A23. While acknowledging (*id.* at A25) that "eligibility determinations for the categorically needy do not involve spend downs * * *," the court deemed this difference to be of no significance because it regarded the time period used to compute the spend down amount as the equivalent of the budget period used to compute AFDC eligibility. *Ibid.* The court further concluded that the use of a six-month spend down period conflicted with a congressional desire "to prevent the States from pursuing * * * more restrictive treatment of the medically needy" than the categorically needy. *Id.* at A26.

SUMMARY OF ARGUMENT

1. Since the inception of the Medicaid program, a regulation issued by the Secretary of Health and Human Services has authorized Massachusetts, and other participating states, to grant Medicaid benefits to an applicant whose income exceeds the eligibility standard, when, over a six-month period, the applicant's "excess income" is "spent down" to the designated level. This regulation has been upheld as a reasonable interpretation of the Medicaid Act by the two federal courts of appeals that have considered the question. *Hogan* v. *Heckler*, 769 F.2d 886 (1st Cir. 1985); *DeJesus* v. *Perales*, 770 F.2d 316 (2d Cir. 1985). As these courts have recognized, there is no basis in either the language or legislative history of the Medicaid Act for invalidating the Secretary's longstanding regulation. The plain language of the statute expressly grants broad authority to the Secretary to "prescribe[]" rules on how to take the costs of medical care into account in determining

Medicaid eligibility. See 42 U.S.C. 1396a(a)(17). In addition, the legislative history confirms that the Secretary is to have broad discretion in implementing this intricate statute. As this Court has repeatedly confirmed, when the Secretary adopts a rule pursuant to an express grant of authority, that rule is " 'entitled to more than mere deference or weight * * *.' Rather, the Secretary's [rule] is entitled to 'legislative effect * * *.' " *Schweiker* v. *Gray Panthers*, 453 U.S. 34, 44 (1981), quoting *Batterton* v. *Francis*, 432 U.S. 416, 425-426 (1977).

The Secretary's spend down regulation is particularly compelling because it was adopted at the inception of the Medicaid program. On at least three subsequent occasions Congress has amended the statutory provisions dealing with the eligibility standards of the medically needy and has not disapproved of the Secretary's policy. Indeed, Congress expressly ratified the Secretary's spend down regulation in the legislative history of the 1982 amendments to the Act. Clearly, there is no basis for setting aside this longstanding administrative interpretation.

Finally, the Secretary's authorization of a six-month spend down period makes fiscal sense and is faithful to the Act's policy of focusing the "limited resources * * * [for] welfare" (*Gray Panthers*, 453 U.S. at 48) on those " 'people [who] are the most needy * * *.' " *Schweiker* v. *Hogan*, 457 U.S. 569, 590 (1982), quoting H.R. Rep. 213, *supra*, at 66. High medical costs that reduce a claimant's income to Medicaid eligibility levels over a six-month period are far more persuasive indicia of hardship than are the medical costs incurred in any one-month period, which may be idiosyncratic and not present a true picture of a claimant's financial condition. The Secretary's regulation permits the states to focus their scarce resources on the former group, who obviously

have the greater need for assistance. Furthermore, use of a six-month spend down eases the administrative burden placed on the states. It requires that they compute Medicaid eligibility on a semi-annual rather than a monthly basis, thus allowing limited state funds to be spent on medical care rather than on the administration of this massive program.

2. The decision below turns in large part on a misinterpretation of the term "same methodology" in 42 U.S.C. 1396a(a)(10)(C)(i)(III). Because the AFDC program, by definition, contains no spend down mechanism, there is no AFDC "methodology" to apply to the spend down period. Moreover, the legislative history explaining the term "methodology" undermines the state court's construction and supports the Secretary's reading of the statute. That history shows that the statutory reference to "methodology" has nothing to do with the computation of the spend down amount.

3. Nor can the decision below be justified by the "comparability" requirement of 42 U.S.C. 1396a(a)(17). That requirement is irrelevant to the spend down computation, since it appears in the very same section of the statute in which Congress conferred broad authority upon the Secretary to determine how the spend down computation should be performed. It is this specific grant of authority, and not the general "comparability" language, that governs here.

In sum, the state court was not free to set aside the Secretary's regulation simply because it preferred another interpretation of this complex statutory scheme. The language of the Act, the legislative history, and the administrative practice compel the conclusion that Congress did not mandate a one-month spend down period. In these circumstances, the Secretary's reasonable and longstanding regulation must be upheld.

ARGUMENT

THE SECRETARY'S REGULATION AUTHORIZING UP TO A SIX-MONTH PERIOD FOR COMPUTING EXCESS INCOME THAT MUST BE SPENT DOWN TO QUALIFY FOR MEDICAID IS CONSISTENT WITH THE LANGUAGE AND POLICIES OF THE MEDICAID ACT AND IS CLEARLY WITHIN THE SCOPE OF THE SECRETARY'S RULEMAKING AUTHORITY

A. The Secretary's Longstanding Regulation Adopted Pursuant To An Express Grant Of Rulemaking Authority Must Be Given Controlling Weight

1. "The Social Security Act is among the most intricate ever drafted by Congress. * * * Perhaps appreciating the complexity of what it had wrought, Congress conferred on the Secretary [of Health and Human Services] exceptionally broad authority to prescribe standards for applying certain sections of the Act." *Schweiker* v. *Gray Panthers*, 453 U.S. 34, 43 (1981). Among those sections is the statutory provision that allows an applicant to qualify for Medicaid by spending down excess income on medical care. 42 U.S.C. 1396a(a)(17) (emphasis added) provides in pertinent part:

> A State plan for medical assistance must * * * include reasonable standards * * * for determining eligibility for and the extent of medical assistance under the plan * * * and provide for flexibility in the application of such standards with respect to income *by taking into account, except to the extent prescribed by the Secretary, the costs * * * incurred for medical care* or for any other type of remedial care recognized under State law * * *.

The statute gives the Secretary broad authority to "prescribe[]" how the costs of medical care should be considered; it does not require the Secretary to compute spend down amounts over any particular

period. See *Hogan* v. *Heckler*, 769 F.2d 886, 896-897 (1st Cir. 1985). Nor does the statute place participating states into an administrative or regulatory straitjacket in considering medical expenses. On the contrary, it expressly allows participating states to "provide for flexibility" in taking into account the costs of medical care. The Secretary's regulation, which permits states to choose a period of up to six months to compute this amount,[9] is faithful to the statute's expressly stated emphasis on "flexibility." See *DeJesus* v. *Perales*, 770 F.2d 316, 324 (2d Cir. 1985); *Williams* v. *St. Clair*, 610 F.2d 1244, 1248 (5th Cir. 1980).[10]

The Secretary's regulation thus is supported by the plain language of the statute. As a regulation adopted pursuant to the explicit grant of rulemaking authority in Section 1396a(a)(17), it is " 'entitled to more than mere deference or weight.' " *Gray Panthers*, 453 U.S. at 44, quoting *Batterton* v. *Francis*, 432 U.S. at 426. It must be given "legislative effect" (432 U.S. at 425) and is entitled to "controlling weight" (*Chevron U.S.A. Inc.* v. *Natural Re-*

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[9] The regulation (42 C.F.R. 435.831) provides:

> The [state Medicaid] agency must determine income eligibility of medically needy individuals in accordance with this section. The agency must use a prospective period of not more than 6 months to compute income.

[10] In addition to the authority conferred on the Secretary by Section 1396a(a)(17), the Act also gives the Secretary the power to "make and publish such rules and regulations, not inconsistent with [the Act], as may be necessary [for its] efficient administration." 42 U.S.C. 1302. Since the Act does not specify any length of time for computing the spend down amount (see *Hogan* v. *Heckler*, 769 F.2d at 889), even in the absence of Section 1396a(a)(17) the general rulemaking authority in Section 1302 would be sufficient authorization for the Secretary to fill in the gaps left by Congress.

sources Defense Council, Inc., No. 82-1005 (June 25, 1984), slip op. 5), unless it is arbitrary, capricious or inconsistent with the Medicaid statute.

2. a. The Secretary's regulation authorizing up to a six-month spend down period is also supported by the legislative history of Section 1396a(a)(17). See *Hogan* v. *Heckler*, 769 F.2d at 892-893. The spend down provision was "designed to correct one of the weaknesses identified in the medical assistance for the aged program." S. Rep. 404, *supra*, at 78. Specifically, Congress focused on the problem of a person "whose income exceeds the [income] limitation adopted by the State" and thus is "ineligible for * * * medical assitance," but whose expenditures for medical care on occasion may reduce his disposable income to a point near the level needed for categorical assistance. *Ibid.* Congress's solution was to direct the Secretary and participating states to "take into account, except to the extent prescribed by the Secretary, the costs * * * incurred for medical care." *Ibid.* Like the language of the statute, which the Senate Report tracks, the Report shows that Congress conferred broad discretion on states and the Secretary in taking into account the costs of medical care in determining the Medicaid eligibility of the medically needy. See *Hogan* v. *Heckler*, 769 F.2d at 893. The House Report contains virtually identical language. See H.R. Rep. 213, *supra*, at 68.

Nothing in the legislative history indicates that Congress intended to mandate any particular spend down period, much less a one-month period. Indeed, to the extent Congress expressed any view on the length of the spend down period, it directly contradicted the state court's conclusion that a one-month period is required. The House Report, in describing the effect of the spend down amount, used a *one-year* period to illustrate the operation of the spend down

concept. See H.R. Rep. 213, *supra*, at 68 (emphasis added) ("If the test of eligibility should be *$2,000 a year*, an individual with income in excess of that amount shall not be required to use his income [on medical care] to the extent he has remaining less than $2,000."). In light of this reference to a possible *annual* spend down computation, there is no basis upon which to conclude that the Secretary's authorization of a six-month period conflicts with the Act. See *Hogan* v. *Heckler*, 769 F.2d at 893.

b. It also is significant that the Secretary's decision to authorize a spend down period of up to six months was included in the first set of Medicaid instructions issued by the Department of Health, Education, and Welfare (*Handbook of Public Assistance Administration—Supplement D* § D-4220(A)(4) (June 17, 1966)); and it was included in the first set of Medicaid regulations adopted in 1969. 34 Fed. Reg. 1321 (codified at 45 C.F.R. 248.21(a)(4) (1970)). See *DeJesus* v. *Perales*, 770 F.2d at 322-323 n.8; *Hogan* v. *Heckler*, 769 F.2d at 893 nn.13, 14. Thus, the administrative determination was made immediately after the Act's passage "by the men charged with the responsibility of setting its machinery in motion, of making the parts work efficiently and smoothly while they are yet untried and new." *Norwegian Nitrogen Products Co.* v. *United States*, 288 U.S. 294, 315 (1933); see *Andrus* v. *Shell Oil Co.*, 446 U.S. 657, 667-668 (1980).

These principles are particularly appropriate where, as here, Congress has forgone opportunities to alter the Secretary's view. On no less than three occasions since the agency adopted its spend down policy in 1966, Congress has amended the provisions of the Medicaid Act dealing with eligibility standards for the medically needy; not once has it disapproved of

the Secretary's policy.[11] In fact, as we discuss below (pages 22-23), in considering one of the most recent amendments to the Act, Congress expressly approved of the regulation at issue here. See H.R. Rep. 97-757, 97th Cong., 2d Sess. Pt. 1, at 13 (1982). In such circumstances, where Congress is aware of the Secretary's construction and has seen fit not to overturn it, the courts are bound to conclude that the agency has correctly discerned the legislative intent. See *United States* v. *Rutherford*, 442 U.S. 544, 554 (1979). See also *EEOC* v. *Associated Dry Goods Corp.*, 449 U.S. 590, 600 n.17 (1981); *Board of Governors* v. *First Lincolnwood Corp.*, 439 U.S. 234, 248, 251 (1978); *Apex Hosiery Co.* v. *Leader*, 310 U.S. 469, 489 (1940).

3. Finally, the Secretary's regulation, and the State's decision to use a six-month spend down period, are fully consistent with the policies underlying the Medicaid program. As noted above, states are not obliged to offer Medicaid to the medically needy; the decision whether to participate in the program is left to the discretion of each state. See *Schweiker* v. *Hogan*, 457 U.S. at 573. Congress made this coverage optional so that the "most needy" would "have the first call upon the resources of the States to provide medical care." H.R. Rep. 213, *supra*, at 66.

Massachusetts's six-month spend down period is faithful to this policy because it allows the State to focus its resources on those most in need of assistance. See *Hogan* v. *Heckler*, 769 F.2d at 889; cf. *Schweiker* v. *Hogan*, 457 U.S. at 590. Unquestionably, a person whose medical expenses for one month may bring him below the Medicaid eligibility limit is not as needy

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[11] See Pub. L. No. 93-233, § 13(a)(3), 87 Stat. 960; Pub. L. No. 97-35, § 2171(a), 95 Stat. 807; Pub. L. No. 97-248, § 137(b)(8), 96 Stat. 378.

as someone who incurs more substantial medical expenses for six months. As the Second Circuit noted, "[u]sing a one-month spend-down * * * would mean that individuals with relatively high monthly incomes might qualify for Medicaid coverage of a substantial part of a larger hospital bill received in a single month, even though such individuals would have excess income in subsequent months that could be used to help pay the bill." *DeJesus* v. *Perales*, 770 F.2d at 322; see *Hogan* v. *Heckler*, 769 F.2d at 990 n.10. Massachusetts, like many other participating states, has chosen not to extend its Medicaid program to such individuals, and by limiting benefits to those most needy, is able to offer a wider range of medical services and a more generous standard of income eligibility. 42 U.S.C. 1396, 1396a(a)(10)(C)(i)(II) and (C)(iv); 42 C.F.R. 440.220.

The lower court's reasoning, however, would require Massachusetts, and some 28 other states and the District of Columbia, to expand their Medicaid programs dramatically to include persons who might have high medical costs for only a single month. Indeed, Massachusetts estimates that in the first year alone the change to a one-month spend down period would cost an additional $20 million, or more than 40% of the State's total expenditures for the AFDC-related medically needy. See S.J.C. App. 186.[12] This change would force a significant reallocation of the resources of the State and might lead to a reduction in the benefits presently offered to those persons considered the most needy. When faced with the prospect of such increased costs, some states might seek to keep expenses constant by eliminating coverage for

[12] Similarly, in *DeJesus* v. *Perales*, 770 F.2d at 320, it was estimated that New York would incur annual additional expenditures of $78 million.

certain services or by making eligibility standards more restrictive. Other states might even reconsider their decision to offer any optional Medicaid assistance to the medically needy. These results cannot be squared with the policies underlying the Medicaid Act. See *Hogan* v. *Heckler*, 769 F.2d at 899.

In this complex area of social policy, any effort to draw lines among the needy is difficult and subject to criticism. Wherever the line is drawn, those who narrowly fail to qualify are nonetheless needy. Cf. *Schweiker* v. *Hogan*, 457 U.S. at 589-592. That is true whether the spend down period is six months or one month. For example, at respondent Rivera's income level, a one-month spend down would be $100.30. In other words, if she incurred $300 in medical expenses in a particular month,[13] a one-month period would make $199.70 of that total eligible for coverage and would reduce her out-of-pocket cost to $100.30. Suppose, however, that another individual at the same income level had recurring monthly medical expenses of $100. That individual would never become eligible for Medicaid, yet at the end of six months he would be out of pocket $600. Although over six months he would have incurred medical expenses twice that of respondent Rivera's ($600 versus $300), he would receive no Medicaid benefits while she would. As a result, his out-of-pocket costs would be almost six times higher than respondent's ($600 versus $100.30). As this example shows, the decision below does not eliminate harsh consequences, it simply shifts the place where the line is drawn. But that is a decision properly left to the expert agency to which Congress has delegated that responsibility.

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[13] Respondent Rivera alleged that her medical expenses in February 1983 were $314 (J.A. 19).

In addition, the Secretary's regulation significantly eases the administrative burden on those states offering Medicaid to the medically needy, a policy expressly recognized by the Act. See 42 U.S.C. 1302. Since states must recompute Medicaid eligibility at the end of each spend down period, the six-month period "limit[s] the frequency of redetermination of eligibility for the medically needy." *Doe* v. *Wilson*, [1982] Medicare and Medicaid Guide (CCH) ¶ 32,148, at 10,544 (D. Vt. Aug. 16, 1982). The added costs involved in making these more frequent computations would increase state spending not on the medically needy, but on hiring more employees to deal with the dramatically expanded case load. See S.J.C. App. 183-186. Faced with the reality that "[t]here are limited resources to spend on welfare" (*Gray Panthers*, 453 U.S. at 33), the Secretary's decision to ease the administrative burden on participating states and thereby not "dissipate resources that could have been spent on the needy" (*ibid.*) is surely a reasonable one.

B. The Secretary's Regulation Is Consistent With The "Same Methodology" Language Of The Act Since That Language Does Not Refer To The Length Of The Spend Down Period

In holding that the Medicaid Act mandates a one-month spend down period, the court below relied heavily on 42 U.S.C. 1396a(a)(10)(C)(i)(III). In pertinent part, that provision states (emphasis added):

> [T]he methodology to be employed in determining [medically needy] eligibility * * * shall be the *same methodology* which would be employed under the supplemental security income program in the case of groups consisting of aged, blind, or disabled individuals in a State in which such program is in effect, and which shall be the same methodology which would be employed under the appropriate State plan * * *

> to which such group is most closely categorically related in the case of other groups * * *.

The court reasoned that the phrase "same methodology" must include the length of time used to compute the spend down amount. Since the budget period for AFDC is one month (see 42 U.S.C. 602(a)(13)), the court concluded that it must be one month for the Medicaid spend down period as well. As both the First and Second Circuits have held, this conclusion is based on an erroneous understanding of the word "methodology." *DeJesus* v. *Perales*, 770 F.2d at 324-326; *Hogan* v. *Heckler*, 769 F.2d at 899-901. Neither the language of the statute nor the legislative history supports the state court's analysis. Indeed, as we now show, there are clear indications that Congress endorsed the Secretary's interpretation.

1. The statutory language provides no support for the state court's conclusion that "methodology" must include the length of the spend down period. The Medicaid Act provides no definition of the term "methodology," much less one that embraces the state court's construction. Accordingly, it is the Secretary's interpretation to which the Court must look for guidance. See *Connecticut Department of Income Maintenance* v. *Heckler*, No. 83-2136 (May 20, 1985), slip op. 6. In the Secretary's view, the "same methodology" requirement refers only to those computations common to determining AFDC eligibility and Medicaid eligibility—*i.e.*, what income or resources are includable, how particular types of income (such as interest or court-ordered support) are treated, and what deductions or disregards to income are available. See 42 C.F.R. 435.831(a)(1)-(3). The spend down concept is not common to both programs. Since AFDC eligibility is categorical, there is no spend down computation. Thus, the spend down computation, a step unique to the Medicaid program,

cannot be governed by AFDC "methodology" because no such "methodology" exists. In these circumstances, the Secretary's reading of language left undefined by Congress is patently reasonable. See *DeJesus* v. *Perales*, 770 F.2d at 326.

Rather than look to the Secretary's expertise for guidance, the state court instead substituted its preferred reading of a highly technical statute. In doing so, the court misconceived its role. Where, as here, the agency is entrusted with interpreting the statute, the issue for the court is not whether the agency's construction is the only reasonable one or whether the court agrees with that construction. See *Connecticut Department of Income Maintenance* v. *Heckler*, slip op. 6. Rather, the question is whether "it is *a* reasonable interpretation of the relevant provisions." *American Paper Institute, Inc.* v. *American Electric Power Corp.*, 461 U.S. 402, 423 (1983) (emphasis in original). See *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, slip op. 5-6. Here, the legislative history plainly shows that the Secretary's interpretation of the term "methodology" is reasonable; in fact, it is the only plausible interpretation.

2. The "same methodology" requirement was enacted as part of the technical corrections to the Medicaid Act made by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Pub. L. No. 97-248, § 137(b)(8), 96 Stat. 378. This legislation was passed in response to regulations promulgated by the Secretary pursuant to a 1981 amendment to the Medicaid Act made in the Omnibus Budget Reconciliation Act of 1981 (OBRA). Pub. L. No. 97-35, § 2171(a)(3), 95 Stat. 807. The Secretary read OBRA's amendment of 42 U.S.C. 1396a(a)(10)(C)(i) as permitting the states to use income and resource standards and criteria for the medically

needy that differed from those used for the categorically needy. Consistent with that interpretation of the 1981 amendment, the Secretary issued regulations authorizing states to adopt different standards for computing income and available resources—steps common to AFDC eligibility and to Medicaid eligibility for the medically needy. These regulations had nothing whatever to do with the spend down computation. (The regulation governing the spend down was unchanged by these 1981 regulations.) See *Medicaid Program; Medicaid Eligibility and Coverage Criteria*, 46 Fed. Reg. 47976 (1981).

The next year, in TEFRA, Congress amended Section 1396a(a)(10)(C)(i) to include the "same methodology" requirement, specifying that its sole intent was to disapprove of the Secretary's 1981 regulations. The House Report explaining the "same methodology" requirement clearly demonstrates that the spend down regulation was not one of Congress's concerns. H.R. Rep. 97-757, 97th Cong., 2d Sess. Pt. 1, at 13 (1982) (emphasis added):

> [T]he 1981 Reconciliation Act made no changes in the applicable income and resource eligibility rules.
>
> Unfortunately, the Department, in its interim final rule of September 30, 1981, 46 Fed. Reg. 47976, assumed that the conferees had intended to give the States extensive flexibility in this area as well. This is simply incorrect. When the Statement of Managers of the conference committee report spoke of providing the States "with flexibility in establishing eligibility criteria and scope of services within the medically needy program to address the needs of different population groups more appropriately," (H.R. Rep. 97-208, p. 971), it was referring to the service package and coverage group provisions, not inviting a wholesale rewriting of current income

> and resource standards and methodologies. This amendment makes clear that the Department had no authority to alter the rules that applied before September 30, 1981, with respect to medically needy income levels, medically needy resource standards, and the methodology for treating medically needy income and resources. *The Committee bill reaffirms the financial requirements previously in effect for the medically needy (42 C.F.R. sec. 435.800-435.845).*

The language in the House Report is critical in two respects. First, in emphasizing that the "same methodology" requirement was intended to overrule only the 1981 regulations dealing with matters other than spend down, the Report made clear that the spend down period was in no way affected by the amendment. See *DeJesus* v. *Perales*, 770 F.2d at 727; *Hogan* v. *Heckler*, 769 F.2d at 901. Second, the Report expressly approved the pre-1981 OBRA regulations, which contained the regulation authorizing a six-month spend down (42 C.F.R. 435.831). As the First Circuit noted in *Hogan* v. *Heckler*, 769 F.2d at 901 (emphasis in original): "*the quoted Report specifically 'affirm[ed] the financial requirements' previously contained in 42 C.F.R. §§ 435.800-435.845. This included the regulation challenged in this action allowing a six month spenddown period, 42 C.F.R. § 435.831.* * * * It is hard to imagine a clearer indication that Congress *did not* intend to equate the length of the spenddown period with the length of the budget period used to determine income."

That Congress did not intend to abrogate the spend down regulation is obvious from an examination of the 1981 regulations to which the "same methodology" language was directed. The preamble to the 1981 regulations discussed the concept of methodology, and conclusively establishes that the spend down

period was not included (46 Fed. Reg. 47980 (1981) (emphasis added)):

> G. *Treatment of Income and Resources*
>
> 1. *Provisions:* States are no longer required to apply a uniform methodology for treating income and resources in such matters as *deemed income, interest, court-ordered support payments, and infrequent and irregular income.* Rather the State plan must specify the methodology that will be used; and that methodology must be reasonable. (See 42 C.F.R. 435.850-435.852 and 436.850-436.852, as added by this final rule.)
>
> 2. *Discussion:* Before the 1981 Amendments, the methodology *for treatment of income and resources* of the medically needy depended on the individuals' relationship to a specific cash assistance program. For example, the methodology for deeming the income of medically needy aged, blind, and disabled was taken from the SSI program. This was based on the former wording of section 1902(a)(10) of the Act that described the medically needy, in part, as individuals who "except for income and resources" would be eligible for cash assistance and for Medicaid as categorically needy. Furthermore, section 1902(a)(17)(C) of the Act required that the methodology for the treatment of income and resources be reasonable and gave the Secretary authority to prescribe standards regarding that methodology.

Thus, the term "methodology," as used in the preamble to the 1981 regulations, referred solely to the general treatment of income and resources; it did not include the length of the spend down period. Nor was 42 C.F.R. 435.831 (which authorizes the use of a six-month spend down period) identified as a regulation

relevant to the change in permissible "methodology." Since the 1982 TEFRA amendment adding the "same methodology" language sought to undo only the changes made by the 1981 regulations, and those regulations clearly did not affect the spend down period, the reference to "methodology" in 42 U.S.C. 1396a(a)(10)(C)(i)(III) cannot sensibly be read to include spend down. See *DeJesus* v. *Perales*, 770 F.2d at 327; *Hogan* v. *Heckler*, 769 F.2d at 901.[14] Accordingly, the state court's conclusion that the 1982 amendment to the Act disapproved of HHS's regulation authorizing up to a six-month spend down period must be rejected.[15]

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[14] Subsequent legislative history further buttresses the Secretary's reading of the "same methodology" language. See *DeJesus* v. *Perales*, 770 F.2d at 326 n.12. In the Deficit Reduction Act of 1984, Congress amended Section 1396a(a)(10)(C)(i)(III) to impose a moratorium on the Secretary's disapproval of state Medicaid plans that might be inconsistent with the "same methodology" language of Section 1396a(a)(10)(C)(i)(III). See Deficit Reduction Act of 1984, Pub. L. No. 98-369, § 2373(c), 98 Stat. 1112. In enacting this moratorium, Congress reaffirmed that its sole intent in using the term "same methodology" was to override the Secretary's 1981 OBRA regulations. See H.R. Rep. 98-861, 98th Cong., 2d Sess. 1366-1367 (1982).

[15] The state superior court (Pet. App. A43) attributed significance to a provision in the 1981 OBRA that mandated one-month budgeting to calculate AFDC benefits. See Pub. L. No. 97-35, § 2315(a), 95 Stat. 855 (codified at 42 U.S.C. 602(a)(13)(A)). According to the state court, this represented an implicit repeal of the Secretary's longstanding regulation and implicitly required that the spend down amount be computed over a one-month period. The court's analysis is flawed in several respects. First, the legislative history of the change makes clear that it was aimed solely at correcting problems in the AFDC program. See S. Rep. 97-139, 97th Cong., 1st Sess. 516-517 (1981). Nothing in this amendment to the AFDC statute or its legislative history even hints at an intent

C. The Secretary's Regulation Is Consistent With The "Comparability" Requirement Of The Act

In the courts below, respondents also claimed that the Secretary's six-month spend down regulation conflicted with the "comparability" requirement of 42 U.S.C. 1396a(a)(17). Although the Supreme Judicial Court did not address that issue, respondents (Br. in Opp. 8 & n.4) rely on it as a basis for defending the judgment below.[16]

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to alter the Secretary's regulation authorizing a six-month spend down period under the Medicaid Act. The state court's reliance on this AFDC amendment therefore is flatly inconsistent with the settled rule that repeals by implication are disfavored. *Parsons Steel, Inc.* v. *First Alabama Bank*, No. 84-1616 (Jan. 27, 1986), slip op. 5; *Morton* v. *Mancari*, 417 U.S. 535 (1974). Second, as the First Circuit noted in *Hogan* v. *Heckler*, 769 F.2d at 901-902, although OBRA amended the AFDC statute to mandate one-month budgeting for calculating benefits, the 1982 House Report on TEFRA states that in OBRA Congress "expressly approved of [the Secretary's] regulations, including [the spend down regulation]." This explicit endorsement of the Secretary's spend down regulation surely nullifies any contrary inferences to be drawn from the AFDC amendment. Finally, although it was not until 1981 that Congress required a one-month budgeting period for calculating AFDC benefits, many states had previously used a one-month budget (see S. Rep. 97-139, *supra*, at 516), and the pre-existing AFDC statute had required states to determine AFDC eligibility (as opposed to the level of AFDC benefits) on a monthly basis. See 42 U.S.C. (1976 ed.) 602(a)(8) and (28); S. Rep. 97-139, *supra*, at 440. Thus, "throughout the period during which the Secretary's regulation permitting a six-month spend-down has been in force, eligibility for AFDC has been determined by calculating income on a monthly basis." *DeJesus* v. *Perales*, 770 F.2d at 323 n.9.

[16] Respondents also contend (Br. in Opp. 7-8) that another of the Secretary's regulations, 42 C.F.R. 435.401(c), bars the use of a six-month spend down period. That contention has no merit. Section 435.401(c) prevents a state's eligibility requirements for the medically needy from being more restric-

Section 1396a(a)(17) (emphasis added) provides in pertinent part:

> A State plan for medical assistance must * * * include reasonable standards (which shall be *comparable for all groups* and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of [the medically needy], based on the variations between shelter costs in urban areas and rural areas) for determining eligibility for and the extent of medical assistance under the plan * * *.

Respondents alleged in the state courts (J.A. 21-22) that since the AFDC program uses a one-month budget period, Section 1396a(a)(17) requires that a "comparable" period be used for the Medicaid spend down period. The First and Second Circuits correctly rejected this spurious contention. See *DeJesus* v. *Perales*, 770 F.2d at 323-324, 327; *Hogan* v. *Heckler*, 769 F.2d at 891-898.[17]

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tive than those used for the related categorically needy. The Secretary has consistently interpreted that regulation to apply solely to those determinations common to calculating eligibility for categorical assistance and Medicaid. Because AFDC eligibility involves no spend down calculation, it is impossible for the Medicaid spend down to be "more restrictive" than the nonexistent AFDC measure. The Secretary's interpretation of his regulations is thus clearly reasonable and is due the greatest deference. *Ford Motor Credit Co.* v. *Milhollin*, 444 U.S. 555 (1980).

[17] Cases that have read Section 1396a(a)(17) or Section 1396a(a)(10) to require comparability between the medically needy and categorically needy are readily distinguishable. Most important, none of those cases dealt with the spend down period. Instead, they all concerned income and resource computations for determining the Medicaid eligibility of the medically needy—computations that are common to determining eligibility for AFDC. See *Beltran* v. *Myers*, 701 F.2d 91

First, the statute's "comparability" requirement is not relevant to determining the spend down amount. The "comparability" requirement of Section 1396a (a)(17) was a feature of the original Medicaid Act; for nearly two decades, however, the Secretary has interpreted that requirement not to preclude states

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(9th Cir.), cert. denied, 462 U.S. 1134 (1983) (transfer of assets rule); *Caldwell* v. *Blum*, 621 F.2d 491 (2d Cir. 1980), cert. denied, 452 U.S. 909 (1981) (same); *Fabula* v. *Buck*, 598 F.2d 869 (4th Cir. 1979) (same); *Greklek* v. *Toia*, 565 F.2d 1259 (2d Cir. 1977), cert. denied, 436 U.S. 962 (1978) (work expenses deductions from income); *Calkins* v. *Blum*, 511 F. Supp. 1073 (N.D.N.Y. 1981), aff'd, 675 F.2d 44 (2d Cir. 1982) (income disregard rule). Thus, they did not concern the problem presented here—a computation unique to determining the Medicaid eligibility of the medically needy. See *DeJesus* v. *Perales*, 770 F.2d at 328.

These cases differ from this one in another significant respect. In striking down the state Medicaid rules at issue, the courts relied heavily on the fact that the state rules conflicted with the Secretary's regulations that mandated identical treatment for the particular computation. See *Caldwell*, 621 F.2d at 495; *Greklek*, 565 F.2d at 1261 n.5; *Calkins*, 511 F. Supp. at 1093. Here, by contrast, the state's Medicaid rule is affirmatively authorized by the Secretary's longstanding regulation. See *Hogan* v. *Heckler*, 769 F.2d at 898.

Respondents also claim (Br. in Opp. 8) that Massachusetts violates the comparability requirement by treating some AFDC-related medically needy differently from others. In particular, respondents state that in Massachusetts some AFDC-related medically needy qualify for Medicaid without a spend down because Massachusetts uses a Medicaid income eligibility standard that is slightly higher than the AFDC standard (see note 4, *supra*). Respondents then assert that Massachusetts computes the income of this group over one month, but uses a six-month period for those AFDC-related medically needy not in this group. In fact, however, there is no disparity in treatment in computing the spend down amount among the AFDC-related medically needy, because there is no need to perform that computation for persons who already meet the Medicaid standard.

from using spend down periods as long as six months. Indeed, it would be anomalous to conclude that the "comparability" requirement implicitly governs the spend down period when the statute's express reference to the spend down concept, which is at the end of the same subsection, specifies only that state plans must "provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs * * * incurred for medical care." 42 U.S.C. 1396a(a)(17); see also 42 U.S.C. 1396b(f)(2).

Accordingly, Section 1396a(a)(17) gives broad discretion to the Secretary, and to participating states, to determine how to take the costs of medical care into account in determining Medicaid eligibility for the medically needy. This express delegation to the Secretary to determine how much an applicant for Medicaid must spend for medical care refutes respondents' argument that the vague "comparable standards" language reflects Congress's intent that the spend down amount be computed in a specific fashion. See *DeJesus* v. *Perales*, 770 F.2d at 324; *Hogan* v. *Heckler*, 769 F.2d at 893, 896-897.

Second, as this Court has recognized, although Section 1396a(a)(17) requires "comparability among the various 'categories' for which federal assistance [is] available, * * * th[is] provision[] d[oes] not require that the medically needy be treated comparably to the categorically needy in all respects." *Schweiker* v. *Hogan*, 457 U.S. at 587. Thus, it cannot be asserted that the Act mandates *identical* treatment for both the categorically needy and the medically needy in every aspect of determining Medicaid eligibility. If Congress had intended that there be no difference in treatment between the categorically needy and the medically needy, it surely would have

said so. But the statute says that treatment must be "comparable," not identical. As Judge Friendly wrote for the Second Circuit, "[c]omparison invites an examination of differences as well as resemblances." *DeJesus* v. *Perales*, 770 F.2d at 324. And the obvious difference between the categorically needy and the medically needy is that while the former automatically qualify for Medicaid, the latter have excess income that must be spent on medical care before they qualify. See 42 U.S.C. 1396a(a)(17); 42 C.F.R. 435.831(d). The categorically needy have no spend down amount, hence no spend down period. Comparability, therefore, can hardly require identical treatment on the point at issue in this case.

CONCLUSION

The judgment of the Supreme Judicial Court of Massachusetts should be reversed.

Respectfully submitted.

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